STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165398	A. BUILDING _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCURA HEALTHCARE OF BAXTER, LLC	407 SOUTH EAST AVENUE BAXTER, IA 50028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS VKC 11/13/17 Correction date 11/07/2017 The following deficiency relates to the facility's annual health survey. (See the Code of Federal Regulations (42CFR) Part 483, subpart B-C). Complaint #70636 and #71505 & incident #71484 was not substantiated.	F 000	This shall serve as an allegation of compliance; all deficiencies will be corrected by the completion date 11/07/2017	11/07/2017
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistentwith professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to prevent the development of an avoidable heel pressure ulcer (Resident #2). On 6/30/17 the staff identified a heel pressure ulcer. On 7/3/17, the physician ordered a treatment. On 7/5/17, the Director of Nursing ordered the staff to float the resident 's	F 314	Accura Healthcare of Baxter will ensure when a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and when a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Director of Nursing and Assistant Director of Nursing audited all resident's Braden Scale to see who triggered for risk of pressure sores. The residents that were at risk had their care plans reviewed for pressure relieving devices. All resident at risk was evaluated and all residents with concern were addressed. On the weekly pressure ulcer progress report for Resident #2 dated 11/8/2017 reflected wound was yellow surrounding tissue with measurements of 1.0 cm x 0.5 cm x 0 in depth. Resident denied pain. All nurses have been educated to call instead of fax the on-call doctor when discovered a wound, get treatment, put on the hot charts, and then call PCP on the earliest business day.	11/07/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathryn LeNeave — TITLE: Administrator — (X6) DATE: 11/07/2017

A[illegible]ciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that o[illegible]afeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 314	Continued From page 1 heels and apply a soft boot. The sample consisted of 1 resident with a pressure ulcer and the facility reported a census of 26 residents. Findings include: Resident #2 had an annual Minimum Data Set (MDS) assessment with a reference date of 6/28/17. The assessment identified the resident had diagnoses including hypertension (elevated blood pressure), Alzheimer's disease, anxiety and depression. The MDS indicated the resident had short and long term memory problems and severe cognitive impaired for daily decision making. The MDS indicated the resident required extensive assistance of 2 staff members for bed mobility, transfers, toilet use and personal hygiene. The resident depended upon staff for transfers and did not ambulate. The MDS indicated the resident at risk for the development of pressure sores and did not have any pressure sores. A Braden Scale dated 9/26/16 (upon admission), for the prediction of pressure sore risk, identified a mild risk (score of 19) for the development. Nursing Admission Assessment dated 9/26/17 identified skin as cool and dry and no open skin areas. The Care Plan, dated 6/30/17 identified a pressure area located on the left heel. The intervention directed staff to apply bunny boots when up and [keep] pressure off of site. An incident report dated 6/30/17 identified the staff found a pressure sore during cares . The assessment indicated the staff found an area that	F 314	The policy and procedures titled Pressure Ulcer Skin Assessment, dated 7/2010 has been revised to clarify and now states, identified the purpose is to: 1.To promote healing of pressure ulcers 2.To provide follow up for each pressure ulcer 3.To document care provided by licensed nursing staff Random audits will be conducted to ensure any current or new resident admitted, who are at risk of pressure sore have been evaluated for pressure relieving devices. Any further concerns will be taken through the quality assurance meeting and addressed in a timely manner.	

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F 314	Continued From page 2	F 314		

measured 0.3 cm x [by] 0.25 cm x 0.2 cm (centimeters). The report identified the wound as unstageable (unable to see wound bed) with slough (yellow or white dead tissue). Awaiting return fax from doctor. On 7/3/17, the facility received a new physician's order to start Duoderm (moisture retentive type of dressing) to the left heel; change every 3 days until healed.

The Director of Nursing provided education and provided direction to staff on 7/5/17. The typed note directed the staff to place soft heel booties on the resident at all times. Pillows are to be placed under the resident's heels to reduce pressure points. The therapy was notified on 7/5/17 to assess wheelchair positioning which could be a contributor to skin issue.

Weekly pressure ulcer progress report dated 7/6/17 reflected wound measurements of 0.3 cm x .25 cm x 0.2 cm with a red/yellow center.

The wound care nurse assessment dated 7/ 11/17 identified wound measurements of 0.3 cm x 0.2 cm x 0.2 cm and staged as a stage 3 pressure ulcer.

The MDS description of a Stage III ulcer is:

A full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

The wound nurse provided an order to cleanse the left heel and apply collagen powder. Cover the area with hydrogel bordered dressing and change daily and as needed. New order to start

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F 314	Continued From page 3 multivitamin with minerals each day and LiquaCel (protein drink to promote healing) 30 milliliters daily. Weekly Pressure Ulcer Progress Reports identified the following: On 7/19/17 the wound measured 0.9 cm x 0.5 cm x 0.2 cm, no drainage, no odor and yellow in color. On 7/26/17 the wound measured 0.9 cm x 0.5 cm x 0.2 cm, no drainage, and no odor. On 8/2/17 the physician ordered x-rays of the left heel. The results identified no cortical disruption or bone destruction. The x-ray identified degenerative changes present. The physician recommended a bone scan and the family refused. The wound care nurse assessment dated 8/2/17 indicated wound measurements of 1.5 cm x 0.6 cm x 0.2 cm; Stage III, pink with scattered slough. The wound nurse directed staff to cleanse left heel wound and apply Calcium Alginate (keeps wound moist and prevents infection), cover with semipermeable dressing each day. The Weekly Pressure Ulcer Progress Report dated 8/9/17, identified the wound measurements of 0.6 cm x 0.4 cm x 0 cm, yellow in color. The physician ordered Boost Breeze 60 ml orally three times per day order on 8/11/17. The Weekly Pressure Ulcer Progress Report identified the following:	F 314		

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F 314	Continued From page 4 On 8/16/17, the wound measured 1.0 cm x 0.6 cm x 0.1 cm with scant drainage and yellow in color. On 8/25/17, the wound measured 1.0 cm x 0.5 cm x 0.2 cm; Stage III pink with scattered slough. Continue same treatment. On 8/31/17, the wound measured 0.6 cm x 0.5 cm x 0.2 cm with scant drainage. On 9/6/17, the wound measured 0.6 cm x 0.5 cm x 0.2 cm, no odor and scant drainage. On 9/13/17, the wound measured 1.0 cm x 0.5 cm x 0.2 cm, no odor and scant drainage. On 9/19/17, the wound measured 1.2 cm x 1.9 cm x 0.2 cm, mild odor ad yellow drainage. On 9/27/17, the wound measured 1.2 cm x 1.1 cm x 0.3 cm with a strong odor present, yellow drainage and white and yellow in color. A pre-albumin laboratory blood test dated 10/10/17 identified a level of 25 (within normal limits). The wound care nurse assessment dated 10/3/17 identified a wound measurement of 0.6 cm x 0.7 cm x 0.2 cm; Stage III with serosanguineous (serous blood and serum in the wound) and moderate drainage. The wound nurse ordered a treatment of Bactroban with collagen powder. Cover with semipermeable absorptive dressing and change each day. During an observation on 10/25/17 at 9:20 am; Staff D, registered nurse, placed a barrier down. Removed old dressing from resident left heel and cleansed with sterile water. Bactroban ointment	F 314		

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F 314	Continued From page 5 mixed with collagen powder applied to the area and covered with semipermeable dressing. No odor, no drainage. Brown raised spot in the middle, callused. Pink surrounding tissue measured 1.0 cm x 0.5 cm x 0 in depth. Resident denied pain to the area. A Care Plan revision on 10/16/17 instructed staff to place moon boots (Prevalon Heel Protectors) on both feet and to assess the wound perimeter, wound bed and healing. The nurse should administer treatments as ordered. The manufacturers for Prevalon Pressure-Relieving Heel Protector boots identified it as comfortably cradles foot and ankle, elevating the heel and relieving pressure. The boot floats the heels and minimizes pressure. The Physician's Order Summary dated 9/24/17 for October, 2017 instructed staff to float heels and use Calcium Alginate to left heel wound, cover with semiparent dressing and change daily. On 10/25/17 at 12:55 pm, Staff A, (certified nursing assistant) was interviewed and stated the resident could move around in wheelchair herself but staff reposition the resident when she is in bed; usually every 2 hours but stated they do not document when they reposition. Staff A stated she has been instructed to keep boots on all the time, even when in bed. On 10/25/17 at 1:12pm Staff B (certified nursing assistant) was interviewed and stated the resident could not reposition herself and staff reposition every two hours, change and take her to the bathroom by Hoyer lift and return her to bed. Staff B stated she did not document when	F 314		

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F 314	Continued From page 6 repositioned. On 10/25/17 at 2:33pm Staff C (licensed practical nurse) was interviewed and stated her expectations with her aides would be to reposition residents who are unable to move on their own and let a nurse know of any skin concerns. On 10/26/17 at 7:45am the Director of Nursing (DON) was interviewed and stated her expectations are for all staff to reposition any resident who is unable to reposition themselves. The DON stated has been the DON since the end of August and unsure how the aides document when they reposition any resident. The DON stated this is something that will be addressed and looked into. This is something that will be addressed and looked into. A policy and procedures titled Pressure Ulcer Skin Assessment, dated 7/2010, identified the purpose is to: 1. To promote healing of pressure ulcers 2. To provide follow up for each pressure ulcer. 3. To document care provided.	F 314		